

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0035477</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Exceptional Care & Training Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/00</u> to <u>06/30/01</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>2601 Woodlawn Road</u> <u>Sterling</u> <u>61081</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Whiteside</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(815) 626-8520</u> Fax # <u>(815) 626-8075</u>		(Type or Print Name) <u>James R. Johnson</u>	
IDPA ID Number: <u>31-1262572</u>		(Title) <u>V.P. of Finance - Jefferson Medical Rehab. Centers, Inc.</u>	
Date of Initial License for Current Owners: <u>08/15/89</u>		(Signed) <u>See Compilation Report</u> (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) <u>Robert A. Thomas Partner</u>	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>Katz, Sapper & Miller, LLP</u> <u>11711 N. Meridian Street, Suite 800, Carmel, IN 46032</u>	
<input type="checkbox"/> Charitable Corp.		(Telephone) <u>(317) 580-8301</u> Fax # <u>(317) 580-8310</u>	
<input type="checkbox"/> Trust		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
IRS Exemption Code <u>501 (c) 3</u>			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>James R. Johnson</u> Telephone Number: <u>(859) 255-0075</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Exceptional Care & Training Center# 0035477 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	<u>79</u>	Skilled Pediatric (SNF/PED)	<u>79</u>	<u>28,835</u>	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>79</u>	TOTALS	<u>79</u>	<u>28,835</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED	<u>28,674</u>			<u>28,674</u>	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,674</u>			<u>28,674</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 99.44%

D. How many bed-hold days during this year were paid by Public Aid?

46 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 08/15/89

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 08/15/89 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified 0 and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 06/30/01 Fiscal Year: 06/30/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	151,441	18,037	3,494	172,972		172,972		172,972			1
2	Food Purchase		115,810		115,810		115,810		115,810			2
3	Housekeeping	89,261	10,216		99,477		99,477		99,477			3
4	Laundry	110,990	14,091		125,081		125,081		125,081			4
5	Heat and Other Utilities			71,373	71,373		71,373		71,373			5
6	Maintenance	60,516	8,659	26,964	96,139		96,139		96,139			6
7	Other (specify):*											7
8	TOTAL General Services	412,208	166,813	101,831	680,852		680,852		680,852			8
	B. Health Care and Programs											
9	Medical Director			12,600	12,600		12,600		12,600			9
10	Nursing and Medical Records	1,209,599	47,228	7,936	1,264,763	28,352	1,293,115		1,293,115			10
10a	Therapy	34,044		13,648	47,692		47,692		47,692			10a
11	Activities	143,100	2,200		145,300		145,300		145,300			11
12	Social Services			661	661		661		661			12
13	Nurse Aide Training	47,182			47,182	(27,509)	19,673		19,673			13
14	Program Transportation		632	632	1,264		1,264		1,264			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,433,925	50,060	35,477	1,519,462	843	1,520,305		1,520,305			16
	C. General Administration											
17	Administrative	63,728		75,650	139,378	(75,336)	64,042	(314)	63,728			17
18	Directors Fees					9,388	9,388		9,388			18
19	Professional Services			321,276	321,276	22,108	343,384		343,384			19
20	Dues, Fees, Subscriptions & Promotions			9,947	9,947	178	10,125	(764)	9,361			20
21	Clerical & General Office Expenses	44,851	11,852	8,260	64,963	25,039	90,002		90,002			21
22	Employee Benefits & Payroll Taxes			416,997	416,997	3,996	420,993		420,993			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,543	3,543	202	3,745	(1,036)	2,709			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			16,136	16,136		16,136		16,136			26
27	Other (specify):* Bad Debt			1,000	1,000		1,000	(1,000)				27
28	TOTAL General Administration	108,579	11,852	852,809	973,240	(14,425)	958,815	(3,114)	955,701			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,954,712	228,725	990,117	3,173,554	(13,582)	3,159,972	(3,114)	3,156,858			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Exceptional Care & Training Center

#0035477

Report Period Beginning:

07/01/00

Ending:

06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			117,195	117,195	84	117,279		117,279			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			359,870	359,870	13,498	373,368	(32,888)	340,480			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,945	3,945		3,945		3,945			35
36	Other (specify):* Amortization			29,581	29,581		29,581	(20,759)	8,822			36
37	TOTAL Ownership			510,591	510,591	13,582	524,173	(53,647)	470,526			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			248,868	248,868		248,868		248,868			42
43	Other (specify):* Day Training	595,367	16,022	37,967	649,356		649,356		649,356			43
44	TOTAL Special Cost Centers	595,367	16,022	286,835	898,224		898,224		898,224			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,550,079	244,747	1,787,543	4,582,369		4,582,369	(56,761)	4,525,608			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **Exceptional Care & Training Center**

0035477

Report Period Beginning: 07/01/00

Ending: 06/30/01

VI. ADJUSTMENT DETAIL**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(32,888)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,000)	27		24
25	Fund Raising, Advertising and Promotional	(764)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(21,795)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (56,447)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(314)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (314)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (56,761)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Exceptional Care & Training Center

ID# 0035477

Report Period Beginning: 07/01/00

Ending: 06/30/01

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Non-Allowable Seminar	\$ (339)	24	1
2	Non-Allowable Travel	(697)	24	2
3	Amortization	(20,759)	36	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(21,795)		49

Summary A

0035477

Report Period Beginning:

07/01/00

Ending:

06/30/01

[illegible]

Facility Name & ID Number Exceptional Care & Training Center# 0035477

Report Period Beginning:

07/01/00

Ending:

06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Swann Special Care Center	Champaign			
		Walter Lawson Children's Home	Loves Park			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Corporate Expenses	\$ 75,650	Hoosier Care, Inc.	100.00%	\$ 75,336	\$ (314)	1
2	V								2
3	V				Note: See schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 75,650			\$ 75,336	\$ * (314)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	11,523			Director Fees	\$ 1,877	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	11,523			Director Fees	1,877	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	11,522			Director Fees	1,878	18.8	3
4	John Foos	Director	Board Meetings	0.00	11,522			Director Fees	1,878	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	11,522			Director Fees	1,878	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,388		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Hoosier Care, Inc.
 Street Address 535 West Second, Suite 105
 City / State / Zip Code Lexington, KY 40508
 Phone Number (859) 255-0075
 Fax Number (859) 281-5150

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18 Director's Fees	Revenue	38,634,444	8	\$ 67,000	\$ 0	5,413,260	\$ 9,388	1
2	19 Professional Services	Revenue	38,634,444	8	157,782	0	5,413,260	22,108	2
3	20 Fees, Subscription & Promotion	Revenue	38,634,444	8	1,271	0	5,413,260	178	3
4	21 Clerical & General Office Exp.	Revenue	38,634,444	8	178,703	0	5,413,260	25,039	4
5	22 Emp. Benefits & Payroll Tax	Revenue	38,634,444	8	28,518	0	5,413,260	3,996	5
6	24 Travel & Seminar	Revenue	38,634,444	8	7,459	0	5,413,260	1,045	6
7	30 Depreciation	Revenue	38,634,444	8	597	0	5,413,260	84	7
8	32 Interest Expense	Revenue	38,634,444	8	96,333	0	5,413,260	13,498	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 537,663	\$		\$ 75,336	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	City of Sterling Bonds-1999A		X	Purchase of Facility	Varies	07/08/99	\$ 4,775,000	\$ 4,710,000	06/01/34	7.1250	\$ 337,339	1	
2	City of Sterling Bonds-1999B		X	Purchase of Facility	Varies	07/08/99	220,000	210,000	06/01/19	10.5000	22,531	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Home Office Allocation										13,498	6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 4,995,000	\$ 4,920,000			\$ 373,368	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 4,995,000	\$ 4,920,000			\$ 373,368	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **Exceptional Care & Training Center**# **0035477** Report Period Beginning: **07/01/00** Ending: **06/30/01****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2000 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	None	8	
	1997		9	
	1998		10	
	1999		11	
	2000		12	
Note: The facility became exempt from property taxes starting 1/1/96.				

		FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Exceptional Care & Training Center COUNTY Whiteside
FACILITY IDPH LICENSE NUMBER 0035477
CONTACT PERSON REGARDING THIS REPORT _____
TELEPHONE () _____ FAX #: () _____

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:
28,676

B. General Construction Type:

Exterior
Brick

Frame
Wood

Number of Stories
1

C. Does the Operating Entity?

☒ (a) Own the Facility
☐ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
☐ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	SNF/PED	63,598	1989	\$ 414,085	1
2					2
3	TOTALS	63,598		\$ 414,085	3

Facility Name & ID Number Exceptional Care & Training Center

0035477

Report Period Beginning:

07/01/00

Ending:

06/30/01

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1989		\$ 2,334,000	\$ 58,000	10-35	\$ 58,000	\$	\$ 995,166	4
5	15			1991	358,311	11,944	30	11,944		119,991	5
6											6
7											7
8											8
	Improvement Type**										
9	Boiler Repair			1990	964		10			964	9
10	Water Unit			1991	8,780	806	10	806		8,780	10
11	PA System			1991	696	68	10	68		696	11
12	Building Addition - Drywall			1991	403	40	10	40		402	12
13	Closet Curtain Track			1991	650	65	10	65		645	13
14	Door			1991	1,614	161	10	161		1,545	14
15	Boiler Repair			1992	6,180	618	10	618		5,837	15
16	Storm Windows			1992	907	91	10	91		856	16
17	Boiler Tubes			1992	7,147	715	10	715		6,672	17
18	Roof			1992	11,118	1,112	10	1,112		10,376	18
19	Kitchen Tile			1992	3,660	366	10	366		3,386	19
20	Heating & Cooling Unit			1992	7,757	776	10	776		7,047	20
21	Shed			1992	1,678	168	10	168		1,539	21
22	Gate & Fence Scars			1992	4,038	404	10	404		3,703	22
23	Landscaping			1992	2,398	240	10	240		2,179	23
24	Drain Replacement			1992	1,576	158	10	158		1,499	24
25	Black Top			1992	575	57	10	57		505	25
26	Light Fixtures			1992	3,743	374	10	374		3,367	26
27	Building Renovation			1993	139	5	30	5		44	27
28	Painting - Laundry			1993	351	35	10	35		316	28
29	Building Renovation			1993	7,106	711	10	711		5,864	29
30	Painting - Laundry			1993	262	26	10	26		215	30
31	Parking Lot			1993	1,800	180	10	180		1,455	31
32	Tile Installation			1993	1,020	102	10	102		839	32
33	Electrical Work			1993	3,255	326	10	326		2,688	33
34	Pipe Installation - Laundry			1993	156	16	10	16		129	34
35	Water Heater Renovation			1993	849	85	10	85		687	35
36	Final Payment - Laundry			1993	1,030	103	10	103		832	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Exceptional Care & Training Center# 0035477

Report Period Beginning:

07/01/00

Ending:

06/30/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Replace Relay in Panel	1993	\$ 1,150	\$ 115	10	\$ 115	\$	\$ 901		37
38	Install New Sewer Lines	1993	4,105	411	10	411		3,287		38
39	New Water Main	1993	12,204	1,219	10	1,219		9,452		39
40	Replace Parts on Sump Pumps	1994	4,034	403	10	403		2,889		40
41	Installed Back Flow Preventor	1994	1,053	105	10	105		735		41
42	Large Toilet Support, Back Stop	1994	923	92	10	92		621		42
43	Deck	1994	814	81	10	81		540		43
44	New Roof	1994	29,435	2,943	10	2,943		18,884		44
45	Tile Floors in Tub Room	1994	4,405	441	10	441		2,830		45
46	Thermocouple on Boiler	1995	2,550	255	10	255		1,615		46
47	New Pump on Boiler System	1995	1,706	171	10	171		1,054		47
48	Air Conditioner Compressor	1995	1,668	167	10	167		1,016		48
49	Replace Fire Alarm	1995	3,743	374	10	374		2,275		49
50	Landscaping	1995	15,000	1,500	10	1,500		9,125		50
51	Counter Top	1995	527	53	10	53		344		51
52	New Door Frame Installed	1995	959	96	10	96		544		52
53	Rebuild Corner of Building	1996	2,000	200	10	200		1,050		53
54	Install Two Bell - Strobes	1996	888	89	10	89		467		54
55	Replace Relay & Timer on Generator	1996	1,325	132	10	132		660		55
56	Rebuild Commercial Water Softener	1996	1,880	188	10	188		1,081		56
57	Replace 3/4 H.P. Motor, Thermocoupler	1996	920	92	10	92		460		57
58	Replace Boiler Pumps and Bearing Assembly	1997	640	64	10	64		283		58
59	Install 3/4 H.P. Motor-Boiler	1997	725	72	10	72		306		59
60	Replace Circulating Pump, Bearings	1997	743	74	10	74		315		60
61	Twenty New Water Faucets	1997	2,296	230	10	230		958		61
62	Vinyl Floor Tile-Resident Room	1997	690	69	10	69		282		62
63	Reseal Parking Area	1997	2,845	285	10	285		1,164		63
64	Air Conditioning Condenser Unit	1997	1,650	165	10	165		633		64
65	Install Conduit	1997	913	91	10	91		341		65
66	Outlets & Wiring	1997	522	52	10	52		190		66
67	Kitchen Fire Suppression System	1998	767	77	10	77		263		67
68	Smoke Detectors	1998	621	62	10	62		212		68
69	Install Pipe & Wire	1998	995	99	10	99		330		69
70	TOTAL (lines 4 thru 69)		\$ 2,876,859	\$ 88,219		\$ 88,219	\$	\$ 1,253,331		70

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,876,859	\$ 88,219		\$ 88,219	\$	\$ 1,253,331	1
2	Smoke Detectors	1998	1,644	165	10	165		551	2
3	Tank Replacement - PIPECO	1998	9,890	495	20	495		1,402	3
4	Generator and Transfer Switch Changeover	1998	2,746	275	10	275		779	4
5	Replace Tubes on Boiler, Galv. Pipes on Water Line	1998	1,690	169	10	169		451	5
6	Installed Boiler Control and Switch for Light	1998	709	71	10	71		195	6
7	Replace Faulty Smoke Detectors, Installed Batteries	1998	973	97	10	97		267	7
8	Installed Tile on Walls & in Staircase (New Addition)	1998	4,495	450	10	450		1,162	8
9	Two Hot Water Tanks Installed	1999	7,119	712	10	712		1,661	9
10	Installation Heavier Electric Service for Dishwasher	1999	1,651	165	10	165		385	10
11	Install New Cooling System Laundry / Kitchen	2000	4,650	233	20	233		349	11
12	Plaster & Drywall existing walls in Residents Rooms	2000	800	80	10	80		113	12
13	Install New Tile in Dining Area & Two Classrooms	2000	4,770	318	15	318		398	13
14	Installed New Thermocouple on West Boiler	2000	353	35	10	35		44	14
15	Replace Thermocouple on West Boiler	2000	140	14	10	14		17	15
16	Replace Thermocouple on Inducer Fan	2000	215	21	10	21		26	16
17	Rebuilt two hopper foot valves / Installed Protectorelay	2000	1,430	143	10	143		179	17
18	Replace Coupler, Motor Mounts, Bearing assy, Impeller	2000	298	30	10	30		37	18
19	Labor to Install 120V Power to New Door Openers	2000	583	58	10	58		68	19
20	Replaced Bearing Assy on Hot Water Return Line	2000	518	52	10	52		61	20
21	Indicator Lamps & Voltage	2000	1,525	114	10	114		114	21
22	Replace Heat Exchanger	2001	962	48	10	48		48	22
23	Replace Heat Exchanger	2001	962	40	10	40		40	23
24	Replace Draft Inducer	2001	1,414	47	10	47		47	24
25	Replace Pipe	2001	530	18	10	18		18	25
26	Replace Clinical Sink	2001	2,304	38	15	38		38	26
27	Furnish & Install Awning	2001	2,771	46	15	46		46	27
28	Labor & Mat-Breaker Panel	2001	3,930	65	15	65		65	28
29	Install Thermo Coupler	2001	944	16	10	16		16	29
30	Install Electric For Dishwasher	2001	820	9	15	9		9	30
31	Reroof Facility and Garage	2001	13,960	93	25	93		93	31
32	Lusterboard Sign	2001	515	9	5	9		9	32
33	Excavation of New Parking	2001	12,415	103	20	103		103	33
34	TOTAL (lines 1 thru 33)		\$ 2,964,585	\$ 92,448		\$ 92,448	\$	\$ 1,262,122	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward	\$ 2,964,585	\$ 92,448		\$ 92,448	\$	\$ 1,262,122		1
2	Renovation Installment	2001 63,363	5,280		5,280		5,280		2
3	Concrete for Canapy & Add.	2001 2,592	173		173		173		3
4	Rounding	1					3		4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)	\$ 3,030,541	\$ 97,901		\$ 97,901	\$	\$ 1,267,578		34

**Improvement type must be detailed in order for the cost report to be considered complete.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,030,541	\$ 97,901		\$ 97,901	\$	\$ 1,267,578	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,030,541	\$ 97,901		\$ 97,901	\$	\$ 1,267,578	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 68,813	\$ 11,396	\$ 11,396			\$ 30,621	71
72	Current Year Purchases	31,397	1,711	1,711			1,711	72
73	Fully Depreciated Assets	365,043	1,851	1,851			365,043	73
74	Corporate Allocation		84	84				74
75	TOTALS	\$ 465,253	\$ 15,042	\$ 15,042	\$		\$ 397,375	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Van Renovation	1991	\$ 5,840	\$	\$		3	\$ 5,840	76
77	Patient Transportation	1995 Ford Van	1998	2,071	414	414		5	1,070	77
78	Patient Transportation	1985 GMC Bus	2000	26,150	3,922	3,922		5	3,922	78
79										79
80	TOTALS			\$ 34,061	\$ 4,336	\$ 4,336	\$		\$ 10,832	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,943,940	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 117,279	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 117,279	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,675,785	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Feasibility on New Parking Lot	\$ 203	92
93			93
94			94
95		\$ 203	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 3,945

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2002 \$ _____

13. /2003 \$ _____

14. /2004 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE <u>64</u></p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE <u>80</u></p>
---	--	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$		\$			
2	Books and Supplies		843		843		
3	Classroom Wages (a)		5,824		5,824		
4	Clinical Wages (b)		7,280		7,280		
5	In-House Trainer Wages (c)		5,726		5,726		
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	19,673	\$	19,673		
10	SUM OF line 9, col. 1 and 2 (e)	\$	19,673				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	13

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 861	\$	1
2	Cash-Patient Deposits	69,786		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 2,300)	928,423		3
4	Supply Inventory (priced at Cost)	9,523		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,288		6
7	Other Prepaid Expenses	5,002		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due From Corporate	5,666,547		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,697,430	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,085		13
14	Buildings, at Historical Cost	3,030,541		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	499,314		16
17	Accumulated Depreciation (book methods)	(1,675,785)		17
18	Deferred Charges	291,119		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,312		21
22	Other Long-Term Assets (specify):	498,083		22
23	Other(specify): Goodwill	582,986		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,642,655	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,340,085	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 38,022	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	69,786		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,240		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,620		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	29,803		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	Medicaid Rate Adjustment	151,086		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 398,557	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,920,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,920,000	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,318,557	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 5,021,528	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,340,085	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,157,748	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,157,748	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	863,779	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 863,780	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,021,528	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,364,842	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,364,842	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	16,673	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 16,673	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	32,888	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32,888	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>DMH Day Training</u>	1,031,745	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,031,745	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,446,148	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	680,852	31
32	Health Care	1,519,462	32
33	General Administration	973,240	33
	B. Capital Expense		
34	Ownership	510,591	34
	C. Ancillary Expense		
35	Special Cost Centers	649,356	35
36	Provider Participation Fee	248,868	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,582,369	40
41	Income before Income Taxes (line 30 minus line 40)**	863,779	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 863,779	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Exceptional Care & Training Center# 0035477Report Period Beginning: 07/01/00Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,005	2,086	\$ 45,327	\$ 21.73	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,026	4,570	88,298	19.32	3
4	Licensed Practical Nurses	19,214	21,058	325,635	15.46	4
5	Nurse Aides & Orderlies	74,268	81,700	778,691	9.53	5
6	Nurse Aide Trainees	2,491	2,518	18,830	7.48	6
7	Licensed Therapist	1,816	1,958	34,044	17.39	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,727	1,999	29,066	14.54	9
10	Activity Assistants	15,011	16,605	114,034	6.87	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,910	2,086	33,754	16.18	13
14	Head Cook	6,024	6,898	65,369	9.48	14
15	Cook Helpers/Assistants	6,177	6,741	52,318	7.76	15
16	Dishwashers					16
17	Maintenance Workers	4,226	4,724	60,516	12.81	17
18	Housekeepers	9,574	10,747	89,261	8.31	18
19	Laundry	11,137	12,363	110,990	8.98	19
20	Administrator	2,003	2,086	63,728	30.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,868	4,262	44,851	10.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	9,476	10,683	136,863	12.81	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Day Training</u>	41,558	46,085	458,504	9.95	33
34	TOTAL (lines 1 - 33)	216,511	239,169	\$ 2,550,079 *	\$ 10.66	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	120	\$ 3,444	1.3	35
36	Medical Director	96	12,600	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	288	1,800	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	361	13,648	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Dental Fees</u>	N/A	6,000	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	865	\$ 37,492		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. See Schedule XIX, Section F
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 15,662 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 248,868
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 35,993
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: PriceWaterhouseCoopers The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.